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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARY ANN ANTONIO PIMENTEL aka MARY ANN PIMENTEL LOYOLA** 5174 Sandbar Cove Way San Diego, CA 92154 **Registered Nurse License No. 681293** Respondent.	Case No. 2010-468 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 22, 2006, the Board of Registered Nursing issued Registered Nurse License Number 681293 to Mary Ann Antonio Pimentel aka Mary Ann Pimentel Loyola (Respondent). The registered nurse license will expire on April 30, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS AND REGULATIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

"...."

7. California Code of Regulations, title 16, section 1442, defines "gross negligence" as follows:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5, states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
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> (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
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> (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
>
> (5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
>
> (6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FACTS

11. On September 2, 2007, Robert N., a 29-year old male, was attacked by a group of people. During the attack, Mr. N. was hit with a beer bottle in the right eye and was punched throughout his body. He fell down three steps and landed on his left side. As a result of his injuries, Mr. N. was taken by ambulance to Sharp Memorial Hospital in San Diego, California.

12. Mr. N. arrived in the emergency room at 2354 hours on September 2, 2007. Both of his eyelids were swollen, although more swollen on the right. Mr. N. reported that his vision was normal at that time. A CT scan was performed and revealed an orbital floor fracture on the right side and a nasal fracture.

13. Mr. N. was admitted to the hospital and arrived at the nursing floor at 0428 hours on September 3, 2007 where he was assessed by Nurse H. Mr. N. complained of right eye and nasal pain. The nursing documentation noted that Mr. N.'s right eye was swollen and ecchymotic (black and blue). Ice packs were applied to the right side of Mr. N.'s face. There was no indication in the notes that Mr. N. had any vision problems at this time.

14. Mr. N. underwent surgery at 1559 hours on September 3, 2007 for reconstructive surgery including the placement of an orbital implant. Dr. B. performed the surgery and was assisted by Dr. V. Surgery was noted to have been uneventful.

15. After surgery at 1713 hours, Mr. N. was sent to the post-anesthesia care unit (PACU) where Nurse L. took over his care. At his arrival in PACU, Nurse L. performed an initial assessment and noted in the patient chart that Mr. N. had slight swelling in the right eye area and that it was ecchymotic and that the surgeon was "aware". Ice packs were applied on Mr. N.'s face and the head of the bed was elevated 35°. Nurse L. also noted that Mr. N.'s vital signs were stable and that he denied needing any pain medication. Nurse L. recorded that Mr. N.'s pain assessment was "0" at 1740 hours, "N" (that is, behavioral and physiological cues indicated no pain) at 1755 hours, "0" at 1800 hours and "N" at 1810 hours. According to Mr. N., he told Nurse L. that he could not see out of his right eye and had pain. Nurse L. did not perform a neurological assessment of Mr. N.'s eye, either visually or by using the light test to check his reaction, during the hour and 7 minutes he was at PACU.

16. Mr. N. was transferred back to the nursing floor at 1825 hours and Nurse G. resumed his care. When he arrived at the floor, Nurse G. noted that Mr. N. was complaining of a lot of pain, ranked a level "8" by Mr. N. and increasing to a level "10" by 1900 hours. Mr. N. was subsequently given Morphine 4 mg and his pain level decreased. Mr. N. advised Nurse G. that he could not see out of his right eye but his complaints of loss of vision were not recorded in the nursing notes. Pain medication was administered at 2100 hours and the scheduled Toradol was given at midnight and at 0600 hours.

17. At 2000 hours on September 3, 2007, Nurse R.G. took over Mr. N.'s care for the night shift. Mr. N. advised Nurse R.G. that he had no vision in his right eye. The nursing notes did not contain any references to complaints of lost vision in Mr. N.'s right eye by Nurse R.G.

18. At 0800 hours on September 4, 2007, the day after surgery, Respondent took over Mr. N.'s care. Respondent performed an assessment of Mr. N., including a neurological check. The left and right pupils were at 3 mm and left and right eye pupil reaction was noted as "brisk." Respondent noted that Mr. N.'s right eye was ecchymotic and swollen and that Mr. N. could only slightly open his right eye. Respondent further noted that Mr. N. reported not being able to see with the right eye. Respondent asked Mr. N. whether this was something new. Mr. N. advised Respondent that he had not been able to see with his right eye since surgery and that he reported it to the nurses. Respondent did not review the patient's chart to see if loss of vision had been charted before. Respondent did not contact the doctor or advise the charge nurse of Mr. N.'s reported loss of right eye vision. Respondent assessed Mr. N. again at 1000 hours but did not perform another neurologic check while she was on duty that day.

19. At approximately 1430 hours on September 4, 2007, Nurse Practitioner H. visited Mr. N. because he was supposed to be discharged that day. Mr. N. told Nurse Practitioner H. that he could not see out of his right eye. Nurse Practitioner H. conducted a visual examination and neurological assessment of Mr. N. and determined that he had right eye blindness. Nurse Practitioner H. tried to reach the doctor who performed the surgery. When she learned he was out of town at a conference, she contacted the trauma surgeon, who subsequently examined Mr. N. The trauma surgeon then telephoned Dr. Z. (the opthalmalogist) to advise of Mr. N.'s condition

and Nurse Practitioner H. telephoned Dr. V. because he had assisted in the first surgery. Dr. V. recommended that Mr. N. see Dr. Z. and also ordered a right orbit CT scan to rule out a retrobulbar hematoma.[1] At 1435 hours, Dr. Z. called Respondent on the floor and requested that Mr. N. be taken to the ER eye center for evaluation at 1700-1730 hours. Because of a mix-up with the CT scan order, the CT scan was not performed until after Dr. Z. examined Mr. N.

20. When Mr. N. was examined by Dr. Z. approximately 24 hours after surgery, his right eye was bulging and intraocular pressures were high. A canthotomy[2] was performed to relieve pressure. A CT scan of the right eye was performed at 1827 hours at which time a new hematoma was discovered in the right orbit. The hematoma was detected approximately 25 hours after the first surgery. As a result, Mr. N. was taken back to surgery that evening to remove the orbital implant from the first surgery.

21. Mr. N. never recovered sight in his right eye due to the compression of the optic nerve caused by the hematoma. According to Dr. Z., if the hemorrhage had been caught within two hours of onset, Mr. N.'s vision could have been saved.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence as defined in title 16, California Code of Regulations, section 1442, in that during her post-operative care of Mr. N., Mr. N. advised Respondent that he could not see out of his right eye and that he had told his previous nurses about this however, Respondent did not investigate further by reviewing the previous nursing records to determine whether this problem had been addressed and did not contact her charge nurse or the physician. Respondent knew or should

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[1] "Retrobulbar hematoma is bleeding in the potential space surrounding the globe. It results from blunt trauma as well as from retrobulbar injection and operative intervention. This entity can compromise vision, so immediate recognition and intervention are warranted. Bleeding typically results from injury to the infraorbital artery or one of its branches. Accumulation of blood results in an increase in pressure, ultimately compressing blood vessels and other structures." **James G. Adams,** ***Emergency Medicine, at http://www.expertconsultbook.com (accessed March 23, 2010)***

[2] A canthotomy is an incision of the canthus, which is either corner of the eye where the upper and lower eyelids meet.

have known, that failing to respond to patient complaints of loss of vision after eye surgery could have, and in fact did, jeopardize Mr. N.'s health or life as more fully set forth in paragraphs 11-21 above, and incorporated by this reference as though set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

23. Respondent is subject to disciplinary action under Code section 2761(a)(1) for incompetence as defined in title 16, California Code of Regulations, sections 1443 and 1443.5, in that Respondent did not act as an advocate for her patient by initiating action to improve health care by investigating whether action was being taken to address Mr. N.'s complaints of vision loss, as more fully set forth in paragraphs 11-21 above, and incorporated by this reference as though set forth in full herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 681293, issued to Mary Ann Antonio Pimentel aka Mary Ann Pimentel Loyola;

2. Ordering Mary Ann Antonio Pimentel aka Mary Ann Pimentel Loyola to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/29/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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